

Statement for the Record
Of
The American College of Obstetricians and Gynecologists
Submitted by:
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Before the
House Committee on Energy and Commerce
Subcommittee on Health
Regarding
Combating the Opioid Crisis:
Improving the Ability of Medicare and Medicaid to Provide Care For Patients
April 11, 2018

Chairman Burgess, Ranking Member Green, and distinguished Members of the House Energy and Commerce Subcommittee on Health, thank you for the opportunity to submit a statement for the record in response to your April 11, 2018 hearing titled "Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care For Patients." The American College of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners dedicated to advancing women's health, appreciates the Committee's attention to this important issue. I hope you will view ACOG as a resource and trusted partner as you continue to examine strategies to combat the ongoing opioid crisis.

I am the Executive Vice President and Chief Executive Officer at ACOG and in this capacity am keenly aware of the increase in opioid use disorder and overdose and its impact on the women we serve and their families. My statement will focus on the need for greater access to evidence-based treatment for pregnant and parenting women and the need for responses to opioid use during pregnancy to remain in the public health space and preserve the patient-physician relationship.

Health professionals, public health advocates, and bipartisan policymakers recognize that the United States is in the midst of a major opioid epidemic. The incidence of opioid use disorder (OUD) has risen dramatically over the past few years, including among women of reproductive age and pregnant and parenting women. According to the HHS Office of Women's Health, the number of women dying from overdose of prescription drugs rose 471 percent between 1999 and 2015, compared to 218 percent for men, and heroin deaths among women increased at more than twice the rate of men.ⁱ In rural areas, where the opioid crisis has hit hardest, pregnant women and women experiencing intimate partner violence are among populations with higher prevalence of misuse of prescription pain relievers.ⁱⁱ

Unsurprisingly, the high prevalence of OUD among reproductive age women means more women are using opioids while pregnant. This is also reflected in the rising incidence of neonatal abstinence syndrome (NAS), an expected and treatable medical condition associated with drug withdrawal in newborns exposed to opioids, including medication-assisted treatment,

or other drugs in utero. The unplanned pregnancy rate among women with OUD is 86 percent, a number that far surpasses the national average of 45 percent, making clear the need for increased access to contraception among women with OUD.ⁱⁱⁱ Untreated OUD during pregnancy is associated with significant obstetric morbidity and mortality.^{iv} **Tragically, overdose and suicide are now the leading causes of maternal mortality in a growing number of states, including Texas.**^{v,vi,vii,viii}

During pregnancy, most women who use substances, including opioids, are motivated to change unhealthy behaviors and quit or cut back. Those who cannot stop using have a substance use disorder. In other words, continued substance use in pregnancy is a characteristic of addiction, a chronic, relapsing brain disease.

Evidence-based treatment for pregnant and breastfeeding women with OUD includes the use of medication-assisted treatment (MAT) such as methadone and buprenorphine. MAT is the recommended therapy for treating pregnant women with opioid use disorder, and is preferable to medically-supervised withdrawal, which is associated with higher relapse rates and poorer outcomes, including accidental overdose and obstetric complications. Use of MAT also improves adherence to prenatal care and addiction treatment programs. MAT, together with prenatal care, has been demonstrated to reduce the risk of obstetric complications among pregnant women with OUD.^{ix}

Threats of incarceration, immediate loss of child custody, and other potential punishments drive pregnant and parenting women away from vital prenatal care and substance use disorder treatment. Research has found that **non-punitive public health approaches to treatment result in better outcomes for both moms and babies.** Immediately postpartum, women who bond with their babies, including via skin-to-skin care and breastfeeding, are more likely to stay in treatment and connected to the health care system. Further, breastfeeding is associated with decreased severity of NAS symptoms and reduced length of hospital stay for the newborn.^x Substance use disorder treatment that supports the family as a unit has proven effective for maintaining maternal sobriety and child well-being.

In 2015, the Government Accountability Office (GAO) report titled *Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination* found that “the program gap most frequently cited was the lack of available treatment programs for pregnant women...”^{xi} In 2017, the GAO report titled *Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome* again cited barriers faced by pregnant women with OUD, including “the stigma faced by women who use opioids during pregnancy” and “limited coordination of care for mothers and infants with NAS,” making it “difficult for families to get the resources or support they need.”^{xii}

Medicaid covers 42.6 percent of US births, and plays a critical role in ensuring healthy moms and babies.^{xiii} In 2012, more than 50 percent of pregnant female admissions aged 15 to 44 to treatment for opioid use disorder were covered by Medicaid.^{xiv} That same year, Medicaid covered 81 percent of the \$1.5 billion that hospitals billed for treating NAS.^{xv} As Congress seeks

to address the ongoing opioid epidemic, and in particular its toll on women, infants, and families, Medicaid will continue to be a key factor in ensuring access to treatment.

As the Committee considers policies to address the ongoing opioid epidemic, we urge you to consider the following:

- **Ensure full implementation of the Protecting Our Infants Act: Final Strategy, created pursuant to Public Law 114-91.** The Strategy, released by HHS in 2017, made several recommendations to address gaps in research; gaps, overlaps, or duplication in relevant federal programs; and coordination of federal efforts to address NAS with recommendations regarding maternal and child prevention, treatment, and services. The October 2017 GAO report made one recommendation: to implement the Strategy.^{xvi} However, HHS is clear that “full implementation will be contingent upon funding.”^{xvii} In particular, we urge the Committee to:
 - **Amend H.R. ____, Protecting NAS Babies Act, to develop a strategy to implement both Maternal and Child recommendations outlined in the Protecting Our Infants Act: Final Strategy.** The GAO’s 2017 recommendation to implement the Strategy did not distinguish or prioritize the maternal vs child strategies out of recognition of the importance of the mother-baby dyad when seeking to improve neonatal outcomes following opioid exposure during pregnancy. Limiting the implementation of the Strategy to only the Child recommendations will result in an incomplete and ineffective strategy to reduce NAS and improve child health.
- The need for urgent action to address the rising maternal mortality rate in the United States, which includes an increase in maternal deaths from overdose and suicide. States with maternal mortality review committees (MMRCs) bring together multi-disciplinary health care professionals to review individual maternal deaths and recommend policy solutions to prevent them in the future. MMRCs are critical tools to understanding maternal deaths, including those linked to opioid overdose, and identifying opportunities for prevention. **Advance H.R. 1318, the Preventing Maternal Deaths Act**, introduced by Reps. Herrera Beutler (R-WA), DeGette (D-CO), and Costello (R-PA) to assist states with the creation or expansion of MMRCs.
- Critical gaps in public and private insurance coverage lead to gaps in care or discontinuation of treatment. Women receiving pregnancy coverage through Medicaid or the Children’s Health Insurance Program (CHIP) may lose their access to MAT weeks after giving birth, during a particularly vulnerable time when relapse risk increases if treatment is not continued. **Explore coverage policies that ensure continued access to treatment for women postpartum.**^{xviii, xix}
- **Reject proposals to legislate prescriber practices.** Addressing this ongoing epidemic will require dedication and partnership between policymakers, health care providers, and the public. Mandating prescribing practices and provider education requirements in

federal legislation is an inappropriate political interference in the practice of medicine. Instead, efforts to engage prescribers should focus on collaborative provider partnerships with the federal government through multi-stakeholder efforts to increase public awareness, and provider training and education. Specifically:

- Federal opioid prescribing limits are not supported by data, are not responsive to the variations in surgical specialty and patient population, and are not appropriate for federal legislation.
 - Prescription Drug Monitoring Programs (PDMPs) are a valuable resource and can guide safe prescribing. ACOG recommends that, before prescribing opioids to their patients, ob-gyns and other health care providers take a thorough history of substance use and review the PDMP to determine whether patients have received prior opioid prescriptions.^{xx} **However, we do not support federal prescriber mandates and therefore urge drafters to amend H.R. __, [Medicaid Partnership Act](#), to instead call for modernization and increased interoperability and usability of PDMPs, while strongly urging physicians to check their PDMP.**
 - ACOG has concerns with other legislative efforts to mandate state Medicaid activities with a penalty of a reduced federal medical assistance percentage (FMAP). Penalizing state noncompliance with reduced FMAP could result in reduced physician reimbursement, coverage, eligibility, and benefits. Medicaid will play an important role in addressing the ongoing opioid epidemic, and we encourage the Committee to consider incentives, rather than penalties, to encourage systems changes.
- **Ensure continued access to women’s preventive care and the full range of contraceptives for Medicaid beneficiaries**, including women of reproductive age with OUD, to drive down the high rate of unplanned pregnancies in this group as well as the rate of babies born with NAS. Reject legislative and administrative efforts to condition payment for health care services on factors other than medical and legal qualifications and standards. Congress should not deny federal funds, including reimbursement for covered services provided to Medicaid beneficiaries, to providers, programs, and health care facilities in cases where a provider is qualified to perform those services.
 - **Improve access to the full range of contraceptives for Medicare beneficiaries**, including women of reproductive age with OUD. Medicare does not currently cover contraception for the purposes of preventing pregnancy, despite the fact that more than 900,000 women ages 18-44 receive insurance coverage through Medicare.^{xxi}
 - **Preserve Medicaid’s financing structure and ensure continued and sufficient federal funding to support Medicaid expansion as currently available.** Proposals to reduce federal Medicaid expenditures by shifting costs to states or reducing enrollment or services will limit access to care for low-income women of reproductive age, including pregnant and parenting women, with OUD. Approximately 42.6 percent of births in the U.S. are financed by Medicaid, Medicaid covers the care of 81 percent of infants

diagnosed with NAS,^{xxii,xxiii} and approximately 25 percent of Americans with OUD are Medicaid beneficiaries.^{xxiv} Any changes to the Medicaid financing structure and/or Medicaid expansion will negatively impact access to care for this vulnerable population.

- **Support testing of new models to improve access to treatment for pregnant and parenting women with OUD, including telemedicine pilots.** Treatment gaps remain, despite continued efforts to increase the availability of programs tailored to the unique needs of pregnant and parenting women. Innovative models can help ensure treatment is effective and responsive to women's complex responsibilities, often as the primary or sole caregivers for their families. In addition:
 - The 2015 GAO study confirmed that "the program gap most frequently cited was the lack of available treatment programs for pregnant women."^{xxv} As ACOG works to train more ob-gyns in prescribing buprenorphine and becoming treatment providers for their patients with opioid use disorder, additional capacity building is needed to assist with closing the access gap. **H.R. __, [Provider Capacity Demonstration Project](#), would assist with this effort. ACOG urges drafters to ensure the bill is consistent with evidence-based recommendations for treatment of pregnant and postpartum women.** Specifically, ensure that activities to expand providers with certain qualifications includes the treatment and recovery needs of both pregnant and postpartum women, in accordance with guidelines issued by ACOG. This includes the current recommendation against detoxification of pregnant women, due to high relapse rates and the increased potential for adverse outcomes.
 - **Advance H.R. 3192, the CHIP Mental Health Parity Act**, to ensure that pregnant women with coverage under CHIP have coverage of mental health and substance use disorder treatment.
 - **Ensure Section 501 of the Comprehensive Addiction and Recovery Act (CARA; Public Law 114-198) receives additional funding to improve access for all women seeking treatment.** Section 501 authorized funds for treatment programs tailored specifically for pregnant and parenting women with OUD, including pilot programs to test innovative treatment models. Additional funding is needed to help close the treatment gap for this population.
- Facilitate better collaboration between health care providers and the child welfare system in responding to the rise of opioid use disorder among pregnant and parenting women and NAS. This epidemic is increasingly leading to children being placed in kinship care or foster care homes. State child welfare agencies do not currently have the resources necessary to address the impact of this epidemic on families. Obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.^{xxvi} Our shared priority is that infants born to families struggling with OUD have safe homes, and that the family unit is preserved when possible.

- Section 503 of CARA added requirements for states to develop infant plans of safe care in instances when an infant experiences NAS following opioid exposure in utero. Unfortunately, those requirements came without resources for implementation or clear guidance, and has the potential to unintentionally lump together women who use illicit substances with those in active treatment or with a current prescription from a licensed health care provider. **States need additional guidance, funds, and resources from the federal government to ensure infant safety and to keep families intact when appropriate.**
- States are encountering barriers to providing affected families the services they need to heal. If we are to truly help children impacted by this epidemic achieve their potential, we must apply a treatment-focused public health approach. Unfortunately, our current system is too often a punitive one that leaves pregnant and parenting women less likely to seek treatment and incentivizes placing children in foster care when they could safely remain at home with the appropriate treatment and support services. **Ensure full implementation of the Family First Prevention Services Act** (Division E, Title VII of the Bipartisan Budget Act; Public Law 115-123) to expand access to treatment services for vulnerable families while helping them stay together and heal.
- Expand access to MAT for women of reproductive age, including pregnant and parenting women, by enabling certified nurse-midwives (CNMs) to prescribe buprenorphine. In an ongoing effort to provide the best care for women suffering from OUD, ACOG offers buprenorphine training courses tailored to women's unique health needs for obstetrician-gynecologists and other health care providers. Treating, prescribing, and referring for MAT services are all within the scope of practice for CNMs. **Advance H.R. 3692, the Addiction Treatment Access Improvement Act**, introduced by Reps. Tonko (D-NY) and Lujan (D-NM), to expand the qualified providers able to prescribe MAT.
- **Continue to promote research into pharmacological and nonpharmacological treatments** for both pregnant and breastfeeding women with opioid use disorder; non-opioid pharmacotherapies for pain management for women, including pregnant women; and both pharmacological and nonpharmacological treatments for newborns with NAS.
- **Address barriers to accessing non-pharmacological pain relief**, including transportation and childcare options for women seeking treatment for pain. In addition, the Committee should ensure that acute and chronic pain management with opioids are not denied to women of reproductive age, including pregnant and parenting women, out of concern for NAS when they are otherwise recommended.^{xxvii}
 - **Consider amending H.R. __, [Incentivizing Non-Opioid Drugs](#), to expand incentives to non-pharmacological pain relief.** Ensure that coverage and reimbursement for non-pharmacological pain relief, including physical therapy, is

adequate to increase access to alternatives to opioid medications, when indicated.

Thank you again for the opportunity to submit a statement for the record, and for your thoughtful approach to this issue. We look forward to working closely with you as you evaluate the legislation before you, consider edits, and develop a legislative package to comprehensively address the impact of the ongoing opioid crisis. I hope that you will consider ACOG a trusted partner in this space and will let us know if we can provide any additional assistance.

ⁱ U.S. Department of Health and Human Services Office on Women's Health. Final Report: Opioid Use, Misuse, and Overdose in Women. July 2017. Retrieved from <https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf>.

ⁱⁱ Medicaid and CHIP Payment and Access Commission. Report To Congress On Medicaid And CHIP June 2017. Washington, DC: Medicaid and CHIP Payment and Access Commission; 2017:60-97. Retrieved from <https://www.macpac.gov/wp-content/uploads/2017/06/June-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.

ⁱⁱⁱ Heil S, Jones H, Arria A, et al. "Unintended pregnancy in opioid-abusing women." J Subst Abuse Treat. 2011 Mar, 40(2): 199-202.

^{iv} Maeda, A, et al. (2014) Opioid abuse and dependence during pregnancy: Temporal trends and obstetrical outcomes. Anesthesiology; 121:1156-65.

^v Rayasam R. (2018, April 10). Federal opioid dollars spur Texas' efforts on maternal mortality. *Politico*. Retrieved from <https://www.politicopro.com/health-care/article/2018/04/federal-opioid-dollars-spur-texas-efforts-on-maternal-mortality-472191>.

^{vi} Metz TD, Rovner P, Hoffman MC, Allshouse AA, Beckwith KM, Binswanger IA. Maternal deaths from suicide and overdose in Colorado, 2004–2012. *Obstet Gynecol* 2016;128:1233–40.

^{vii} Maryland Department of Health and Mental Hygiene Prevention and Health Promotion Administration. Maryland Maternal Mortality Review: 2016 Annual Report. Retrieved from http://healthymaryland.org/wp-content/uploads/2011/05/MMR_Report_2016_clean-copy_FINAL.pdf.

^{viii} Pregnancy-Associated Deaths from Drug Overdose in Virginia, 1999-2007: A report from the Virginia Maternal Mortality Review Team. April 2015.

^{ix} Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e81–94.

^x Klamon SL, Isaacs K, Leopold A, Perpich J, Hayashi S, Vendor J, Campopiano M, Jones HE. Treating Women Who Are Pregnant and Parenting for Opioid Use Disorder and the Concurrent Care of Their Infants and Children: Literature Review to Support National Guidance. *J Addic Med* 2017;11(3):178-190.

^{xi} U.S. Government Accountability Office. (2015, February). Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination. (Publication No. GAO-15-203). Retrieved from <http://www.gao.gov/products/GAO-15-203>.

^{xii} U.S. Government Accountability Office. (2017, October). Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome. (Publication No. GAO-18-32). Retrieved from <https://www.gao.gov/assets/690/687580.pdf>.

^{xiii} Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. 2018. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

^{xiv} Smith K and Lipari RN. Women of childbearing age and opioids. The CBHSQ Report: January 17, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from https://www.samhsa.gov/data/sites/default/files/report_2724/ShortReport-2724.html.

^{xv} Medicaid and CHIP Payment and Access Commission. *Supra* note ii.

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- ^{xvi} U.S. Government Accountability Office. (2017, October). *Supra* note xii.
- ^{xvii} Protecting Our Infants Act: Final Strategy. Submitted by the Behavioral Health Coordinating Council Subcommittee on Prescription Drug Abuse. Retrieved from https://www.samhsa.gov/sites/default/files/topics/specific_populations/final-strategy-protect-our-infants.pdf
- ^{xviii} Opioid use and opioid use disorder in pregnancy. *Supra* note ix.
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- ^{xxi} Private and Public Coverage of Contraceptive Services and Supplies in the United States, (The Henry J. Kaiser Family Foundation, July 10, 2015). Retrieved from <https://www.kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/>.
- ^{xxii} Births: Final Data for 2016. *Supra* note xiii.
- ^{xxiii} Medicaid and CHIP Payment and Access Commission. *Supra* note ii.
- ^{xxiv} *Id.*
- ^{xxv} U.S. Government Accountability Office. (2015, February). *Supra* note xi.
- ^{xxvi} Opioid use and opioid use disorder in pregnancy. *Supra* note ix.
- ^{xxvii} *Id.*